Acentra HEALTH

Prior Authorization Vendor for ND Medicaid

Duchenne Muscular Dystrophy Prior Authorization Form

Fax completed form to: 855-207-0250
For questions regarding this prior authorization, call 866-773-0695

ND Medicaid requires that members receiving a new prescription for Duchenne Muscular Dystrophy to meet specific clinical criteria for coverage which can be found at https://ndmedicaid.acentra.com/ndpdl/

Member Name	Member Date of Birth	Member Medicaid ID Number	
Prescriber Name	Prescriber/Rendering NPI	Billing NPI (*medical billing only*)	
Address	City	State	Zip Code
Specialist involved in therapy	Telephone Number	Fax Number	
Diagnosis for this request: ☐ Off-label		Member Weight (kg)	
Requested Drug, Strength, and Directions:		**Dosage Form (e.g., tablet):**	

PART A: INITIAL REQUESTS

1. The diagnosis has been confirmed by the following (select all that apply):
   - ☐ Presence of abnormal dystrophin
   - ☐ Confirmed mutation of the dystrophin gene
2. Did the onset of weakness occur before 2 years of age? ☐ YES ☐ NO
3. Is the serum creatinine kinase activity at least 10 times the upper limit of normal prior to initiating treatment? ☐ YES ☐ NO
4. Was there a trial of a corticosteroid (select all that apply and provide trial dates/duration)?
   - ☐ Prednisone _____
   - ☐ Other: _____ _____
   - ☐ Other: _____ _____
5. Have any of the following significant intolerable adverse effects occurred with use of prednisone? (select all that apply) *Must submit supporting clinical documentation (e.g., chart notes)*
   - ☐ Cushingoid appearance
   - ☐ Central (truncal) obesity
   - ☐ Undesirable weight gain (>10% of body weight gain increase over 6-month period)
   - ☐ Severe behavioral adverse effect
   - ☐ Diabetes and/or hypertension that is difficult to manage
   - ☐ Not applicable
6. Proceed to Part C: Assessment and Outcomes

PART B: RENEWAL REQUESTS

1. For corticosteroid renewal only, which adverse effects have improved since stopping prednisone? (select all that apply) *Must submit supporting clinical documentation (e.g., chart notes)*
   - ☐ Cushingoid appearance
   - ☐ Central (truncal) obesity
   - ☐ Undesirable weight gain (>10% of body weight gain increase over 6-month period)
   - ☐ Severe behavioral adverse effect
   - ☐ Diabetes and/or hypertension that is difficult to manage
2. Proceed to Part C: Assessment and Outcomes

PART C: ASSESSMENT & OUTCOMES*	Baseline Result and Date	Current Result and Date
Scoliosis assessment	Requires surgery ☐ YES ☐ NO	Requires surgery ☐ YES ☐ NO
Left ventricular ejection fraction (LVEF)		
Forced vital capacity (FVC) predicted		
6-Minute Walk Time (6MWT)		
If ambulatory, one of the following:		
☐ North Star Ambulatory Assessment		
☐ 4-Stair Climb		
If non-ambulatory, one of the following:		
☐ Motor Function Measure		
☐ Hammersmith Functional Motor Scale		
☐ Performance of Upper Limb		

* Please note, the member does not have to meet all parameters, but each assessment must be submitted.

If scoliosis assessment, LVEF, and FVC parameter requirements are not met as outlined in the PDL, please provide justification to continue therapy with the requested agent, including what functional parameters are being met and/or preserved:

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the member.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*